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ABSTRACT

The "new homeless" of the eighties and nineties are not only more numerous; they are younger, more likely to use drugs, and they exhibit symptoms of mental illness. Homeless mentally ill individuals typically have estranged family relationships and fewer supportive relationships compared with other homeless persons. They typically have more negative family experiences and feelings of detachment from family. The implications for the utilization of the Adult Attachment Interview as a foundation from which to draw clinically relevant information with homeless and runaway youth may have an impact on future treatment and research. Psychologists can contribute to the treatment of homeless and runaway youth through clinical work involving long-term treatment using knowledge of attachment theory and research. (Contains 47 references.) (Author/JDM)

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HOMELESS AND RUNAWAY YOUTH: ATTACHMENT THEORY AND RESEARCH

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

Biola University

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

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by

Joanne M. Henk

December, 2001

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ATTACHMENT THEORY AND
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Joanne M. Henk

The "new homeless" of the eighties and nineties are not only more numerous; they are younger, more likely to use drugs, and they exhibit symptoms of mental illness . Homeless mentally ill individuals typically have estranged family relationships and fewer supportive relationships compared with other homeless persons. They typically have more negative family experiences and feelings of detachment from family. The implications for the utilization of the Adult Attachment Interview as a foundation from which to draw clinically relevant information with homeless and runaway youth may have an impact on future treatment and research. Psychologists can contribute to the treatment of homeless and runaway youth through clinical work involving long term treatment using knowledge of attachment theory and research.

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ATTACHMENT THEORY AND
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With love and appreciation
To my parents
JOSEPHINE EVELYN RUTH HENK
EDMUND FREDERICK HENK

And to my grandparents, Eva and Anthony Pangie
And Katherine and Edmund Henk

To my brothers Eddie and Steven

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Andrea and David Corbin
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And Uncle Neil Smit
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"The Lord is my shepherd, I shall lack nothing. He makes me lie down in green pastures, he leads me beside quiet waters, he restores my soul. He guides me in the paths of righteousness for his name's sake. Even though I walk through the valley of the shadow of death, I will fear no evil, for you are with me.
Psalm 23:1-4

HOMELESS AND RUNAWAY YOUTH: ATTACHMENT THEORY AND RESEARCH

Introduction

The homeless of today are not only numerous, they are often young, likely to use illegal substances, and exhibit symptoms of mental illness. The least researched of all homeless individuals in the United States are homeless runaway adolescents (General Accounting Office [GAO], 1989) whose early childhood and adolescent histories often reflect poor familial and social attachments.

A homeless adolescent's early childhood history may have been fraught with multiple traumas including physical, psychological, and sexual maltreatment, and further complicated by the complexities of foster care placement. These youth may have been moved from home to home in the foster care system, creating instability in the living environment that results in difficulty trusting and attaching to others (DiPaolo, 1997). Since these adolescents often share similar attachment histories, a brief review of

attachment theory is relevant and will provide the foundation for the present discussion of homeless and runaway youth.

Attachment Theory

The theory of attachment has been evolving from the time of John Bowlby's (1944) work and Harry Harlow's (1960) studies of primate behavior to current studies of human infants and adults. Although the theory continues to be fine-tuned, its major premise has always been that infants (both animal and human) are born with an innate drive to maintain proximity to certain others that helps assure their survival. This concept is of particular relevance to humans, who are born in a complete state of physical dependency, because they remain emotionally attached to particular others even after they (as adults) no longer need caregivers to ensure their physical survival. In addition to infant studies (Ainsworth, Blehar, Waters, & Wall, 1978), attachment research has produced a plethora of studies on adult attachment (Main, Kaplan, & Cassidy, 1985; Hazan & Shaver, 1987, 1990; Bartholomew & Horowitz, 1991). For adolescents, who have not yet achieved full autonomy in regard to providing for themselves, both the physical and emotional aspects of attachment hold considerable import.

Infant Attachment

Attachment research first began in observations of primates (Harlow, 1960). Drawing on evolutionary theory and Harlow's work, Bowlby's ethology and Harlow's research resulted in the understanding that an attachment behavioral system is responsible for infant survival and safety. The infant seeks proximity to caregivers, using them as a safe haven in times of distress, danger, or perceived threat. The major premise of human attachment theory is "the propensity of human beings to make strong affectional bonds to particular others" (Bowlby, 1969/1982, p. 201).

One of the first to explore the issue of attachment, Bowlby (1944), a London psychoanalyst and member of the British Psychoanalytic Society, began to consider the importance of attachment in his work with delinquent adolescents who had experienced parental abandonment. He explored the long-term effects of early loss and studied early separation, evolutionary biology, ethology, cognitive science, and information processing theory.

Bowlby (1969/1982, 1973, 1980) believed that children are born with a biological predisposition to become attached to their caregivers, and that early disturbances in primary attachment relationships can lead to lifelong feelings of insecurity and distortions in the capacity to develop and sustain meaningful relationships. Although this concept is commonly held by today's psychological

community, Bowlby's research was considered revolutionary throughout the period between the 1940s and the 1970s.

More recent formulations have proposed that the attachment system functions continuously to provide children with a sense of "felt security" that facilitates exploration by the child (Ainsworth et al., 1978). Internal representations (internal working models), which form as the child and attachment figures interact, result from two key dimensions: (a) whether or not the attachment figure responds to calls for support and protection and (b) whether or not the self is believed to be the sort of person towards whom someone is likely to respond in a helpful way (Bowlby, 1973). Internal representations are formed by the infant based on experience with the attachment figure (e.g., mother), self, and the environment. These mental representations or internal working models are called "expectations" by contemporary attachment theorists. Expectations suggest the ability of the child to anticipate the future and to make plans (Bartholomew & Horowitz, 1991).

Research has shown that children attach to their mothers even if their mothers are abusive; however, their attachments are not secure. Insecurely attached infants lack a mental representation that the attachment figure is available and responsive to the infant's needs. This lack results in an inability to trust and to depend on future responses of the primary attachment figure, as well as the responses of others (Ainsworth et al., 1978).

According to Bowlby (1969/1982), emotions are also essential in the development of attachment. The formation, maintenance, disruption, and renewal of attachment relationships involves many intense emotions. When the infant experiences positive emotions in relation to attachment, he or she will try to maintain the attachment and will experience sadness with its loss. In fact, when infants are separated from their mothers, they display a predictable series of emotional reactions. The first reaction is protest, which involves crying, active searching, and resistance to others' soothing. The second is despair, which is a state of sadness and passivity. The third—only displayed by human infants—is an active state of detachment that is a defensive disregard for and avoidance of the mother when she returns.

Ainsworth's Strange Situation. Ainsworth (Ainsworth, 1985, 1989; Ainsworth et al., 1978), a Canadian psychologist who collaborated with Bowlby, contributed empirical evidence supporting individual differences in infant patterns of attachment. Her work shifted the focus of attachment theory from clinical inquiry to the study of normal infant development. She studied infants' responses to separation from and reunion with mothers in a structured laboratory procedure known as the Strange Situation (Ainsworth et al.). These structured procedures assessed the quality of the infant-mother attachment through observation of the infants' different responses to the mother when she returned after different separation conditions. Subsequently, conclusions were

drawn regarding the type of mother-child interaction and whether the infant was securely attached to the mother or insecurely attached to the mother.

The Strange Situation includes a series of planned separations and reunions between infant and mother that take place in a laboratory setting. Initially, mother and child enter a toy-filled room. The mother leaves soon afterwards, and a stranger enters. The mother returns to the room a few minutes later, and the stranger leaves. When the mother exits the room a second time, the child is left alone. Mother then returns to the child. The child's responses to mother after each separation are carefully observed, and attachment classification is determined by the quality of infant-mother interactions (Ainsworth et al., 1978).

Classification of infant attachment. The Strange Situation laboratory procedure allows researchers to assess the quality of the infant-mother attachment through observation of the child's response to the mother. Based on the child's responses to the mother, he or she is classified as securely or insecurely attached. Insecurely attached infants either express ambivalence and insecurity or display avoidance during reunion with their mothers upon their return. Therefore, Ainsworth et al. (1978) proposed one category for secure attachment (secure) and two categories for insecure attachment (anxious-resistant and avoidant).

Securely attached children actively seek proximity and contact with their mothers when they return to the room following the brief separations. These children then return to exploration and play, using their mothers as a source of comfort and a secure base from which they can explore and to which they can return with ease. Their mothers are sensitive to their needs, accept their behaviors, and express appropriate affect. Securely attached children are the recipients of a high degree of maternal soothing behavior, and their mothers demonstrate emotional availability through gaze, vocalization, and physical affection (Ainsworth et al., 1978).

Anxious-resistant children display intense approach-avoidance behaviors that indicate their need for their mothers, yet experience seems to have taught them that approaching mother often results in disappointment and rejection. When compared with securely attached children, these children smile less frequently and express ambivalence towards their mothers. They may cry and express discomfort when their mothers attempt closeness, making it difficult for mothers to provide further comfort. These mothers are generally unskilled and provide poor quality relational touch and affective expression (Ainsworth et al., 1978).

Avoidant children appear not to distinguish emotionally between their mothers and the stranger, and avoid their mothers upon their return. Their mothers are rejecting and appear to have a strong aversion to physical contact.

Although these mothers do show affection, it is not usually through bodily contact. When compared to securely attached children, these children smile less frequently and respond less positively to being held and more negatively to being put down. When they cry, they do so for longer periods of time. Their mothers are less sensitive to their children's needs than the mothers of securely attached children, and may have an interfering, abrupt attitude and a mechanical mothering style. Intrusive behavior and over stimulation preclude their ability to adequately respond to their children's cues. Avoidant children are less expressive of affect, yet more angry than securely attached children, although their anger may not be overtly expressed (Ainsworth et al., 1978).

Although one of the three aforementioned attachment classifications (secure, anxious-resistant, and avoidant) as defined by Ainsworth et al. (1978) seemed to apply to most children observed, a growing number of infants were unclassifiable using this three-category model. Subsequently, Main and Solomon (1990) observed more than 200 videotapes and proposed a fourth category of infant attachment: disorganized-disoriented. These infants greeted their mothers when they returned, but then seemed to freeze in place or fall to the ground, a pattern of behavior that did not fit well with any of the existing categories and warranted its own descriptor.

Adult Attachment

Further research in the field of attachment was conducted by Main et al. (1985), who not only studied infant and child attachment patterns, but adult attachment as well. Hazan and Shaver studied romantic love (1987) and love and work (1990) as an attachment process. They developed a self-report classifying adults in 3 categories corresponding to 3 attachment styles in childhood. Bartholomew and Horowitz (1991) studied attachment styles with peers in one study and familial attachment styles in a second study using a self-report and a semi-structured interview that they had developed. They found that attachment styles with peers are meaningfully related to familial attachment styles yet not reducible to representations of childhood experiences. Main et al. (1985) developed an interview-based method of classifying the parent with respect to attachment that is strongly associated with the child's behavior toward that parent during the Strange Situation (Ainsworth et al., 1978). This interview-based classification led Main to develop the Adult Attachment Interview (AAI) to further assess the quality of adult attachment (Main et al.).

The Adult Attachment Interview. The AAI is a semistructured, hour-long protocol consisting of 18 items that begins with a general description of relationships to parents in childhood. After providing five adjectives that best represent the respondent's relationship with each parent, he or she is asked to

relate specific episodic memories that illustrate or support the choice of each descriptor. This procedure may be repeated for other significant attachment figures as well. The interview moves at a relatively rapid pace and requires the respondent to reflect upon and answer fairly complex questions regarding personal life history (Hesse, 1999).

Other items inquire about ways the respondent dealt with being emotionally upset, physically hurt, or ill, as well as how parents or other attachment figures responded. Finally, the respondent is asked about the nature of current relationships with parents and how the respondent believes his or her own experiences of being parented affect his or her parenting style. The interview is then transcribed verbatim, omitting cues to intonation, prosody, or nonverbal behavior, and is used to assess the respondent's ability to produce and reflect upon memories related to attachment while simultaneously maintaining coherent discourse (Hesse, 1999).

Response patterns determine the respondent's adult attachment status. Four AAI classifications (secure-autonomous, preoccupied-entangled, dismissing, and unresolved-disorganized) were designed to parallel infant attachment classifications (secure, anxious-resistant, avoidant, and disorganized-disoriented), which have similar internal working and defensive strategies (Main et al., 1985).

Secure-autonomous adults are comfortable with intimacy and autonomy. These individuals produce an acceptably coherent and collaborative narrative, whether or not their actual experiences were favorable or unfavorable. During the interview, these adults provide sufficient—but not excessive—elaboration on AAI items, as well as appropriate interpersonal interactions with the interviewer (Main et al., 1985).

Dismissing adults provide a discourse that minimizes the discussion of attachment-related experiences. Their transcripts typically are internally inconsistent and include terse responses (e.g., "I don't remember."). Their descriptions of parents or attachment figures are generally favorable to highly favorable; however, they lack supportive evidence for their positive representations and, in fact, often contradict themselves in this regard. Dismissing adults often have children who are classified as avoidant (Main et al., 1985).

Preoccupied adults give lengthy, often angry discussions of childhood interactions with parents or caregivers that may seem to be inappropriately stated in the present tense and/or include discussions of present relationships. Remote topics, vague language, and vacillation of feelings may occur within the same sentence. Preoccupied adults often have children who are classified as anxious-resistant or ambivalent (Main et al., 1985).

An additional AAI category involves a disorganization surrounding discussions of potentially traumatic events or a failure to maintain an organized discourse strategy across the interview as a whole. Unresolved-disorganized adult attachment occurs when substantial lapses in the self-monitoring of reasoning or discourse occur during discussions of past traumatic events (e.g., significant loss experiences, abuse). Unresolved adult attachment has been predicted by disorganized-disoriented infant attachment, the fourth classification that was added to Ainsworth's original three-category system by Main and Solomon (1990).

Although most adults fit in one of these four attachment classifications, Hesse (1999) identified a group of individuals who may be better described by a "cannot classify" category. These individuals' AAI results present a combination of "contradictory and incompatible linguistic patternings" (p. 398). Although this category has not been psychometrically analyzed, it has been found to be associated with adults' histories of psychiatric disorder, marital and criminal violence, and sexual abuse, rather than to any of the infant attachment classifications.

A number of concerns have arisen regarding the validity of the AAI. The AAI does not assess whether or not an adult is securely attached to another person, but simply provides a means of assessing an individual's overall state of mind with respect to attachment and specific states of mind that arise during the

discussion of specific topics. Neither does it measure whether an adult is secure or insecure as an individual. The interview focuses on descriptions and evaluations of relationships to several significant individuals, and a singular classification typically results despite the nature of the early significant attachment relationships (Hesse, 1999).

In short, classification is predicted from the analysis of discourse, rather than from the facts of actual attachment-related experiences. However, the system of scoring provides an understanding of the relationship between language and attachment. In addition to omitting "the facts" of early attachment relationships, no nonverbal cues are included in the analysis. Researchers purport that adding nonverbal cues would decrease the predictive validity of the linguistic scoring system currently utilized (Hesse, 1999; Main et al., 1985).

Hazan and Shaver's three-category model. Contemporary attachment research continues to emphasize the role that affectional bonds (attachments) have in shaping the individual's life (Lopez, 1995). Attachment styles have also been found to be related to work performance and romantic love relationships (Brennan & Shaver, 1995; Hazan & Shaver, 1987, 1990).

Hazan and Shaver (1987) endorsed a three-category model of attachment (secure, anxious-ambivalent, and avoidant) that parallels the original three categories proposed for infant attachment by Ainsworth et al. (1978) and based on a self-report procedure found prevalence rates of adult attachment patterns

that were similar to the prevalence rates that have been found for infant attachment patterns.

Bartholomew and Horowitz's four-category model. Building on the work of Hazan and Shaver (1987, 1990), Bartholomew and Horowitz (1991) were particularly interested in the avoidant attachment category. Findings of their study revealed a clear distinction between two types of avoidant attachment: dismissing and fearful.

Fearful avoidant attachment suggests a sense of unworthiness and unlovability that is combined with expectations that others will be untrustworthy and rejecting. The fearful person avoids close involvement with others for self-protection against anticipated rejection and has a pervasive sense of personal insecurity and distrust of others (Bartholomew & Horowitz, 1991).

Dismissing avoidant attachment suggests at an individual's sense of being worthy of love may be combined with a negative disposition toward other persons. The dismissing person protects against disappointment by avoiding close and intimate relationships as well as by maintaining a sense of independence and invulnerability. He or she downplays the importance of close relationships, restricts emotionality, and emphasizes self-reliance (Hazan & Shaver, 1987).

Bartholomew and Horowitz (1991) also renamed the anxious-ambivalent category, giving this type of insecure attachment the descriptor preoccupied.

Preoccupied attachment suggests one who has a sense of personal unworthiness and a positive expectation of others. The preoccupied person tries to gain the acceptance of valued others and is characterized by an over involvement in close relationships, a dependence on other people's acceptance for a sense of personal well-being, a tendency to idealize other people, and incoherence and exaggerated emotionality in discussing relationships. In addition, these researchers noted that the preoccupied and fearful groups generally experience higher levels of interpersonal distress than the other two groups (secure or dismissing).

Homeless and Runaway Adolescents

Within the past decade, clinical work with homeless and runaway adolescents has been informed by research in attachment theory. Stabilization is necessary for long-term change to take place for these youth (Stefanidis, Pennbridge, Mackenzie, & Pottharst, 1992). A therapeutic model informed by the findings of attachment researchers (Bowlby, 1969/1982); (Ainsworth, 1985); (Main, Kaplan, & Cassidy, 1985); (Hazan & Shaver, 1987, 1990); (Bartholomew & Horowitz, 1991)) seems appropriate for both short-term interventions as well as long-term treatment for homeless and runaway youth. Although these individuals are no longer infants and may not yet be considered adults, the categories of attachment have been shown to be consistent across the literature

(See Table 1.) and can, therefore, be applied to this "in-between" population. Thus far, crisis intervention and short-term stabilization have been the foremost concern of service providers, leaving the potential benefits of long-term treatment from a theoretical attachment perspective unexplored. Following a review of current research relevant to homeless and runaway adolescents, the need for accurate assessment and long-term intervention as informed by attachment theory will be presented.

Table 1

Classifications of Infant and Adult Attachment

Infant Attachment	Adult Attachment		
Ainsworth (Main & Solomon)	Main	Hazan & Shaver	Bartholomew & Horowitz
Secure	Secure-Autonomous	Secure	Secure
Anxious-Resistant	Preoccupied-Entangled	Anxious-Ambivalent	Preoccupied
Avoidant	Dismissing	Avoidant	Dismissing
(Disorganized-Disoriented)	Unresolved-Disorganized-		Fearful-Avoidant

Descriptive Studies of Homeless and Runaway Youth

Research with this population has been conducted at natural street sites, in shelters, drop-in centers, and outpatient medical clinics, and has primarily focused on description of the characteristics of this population (Kipke, O'Connor, Palmer, & Mackenzie, 1995; Yates, MacKenzie, Pennbridge, & Cohen,

1988). Runaway street youth are at a greater risk for medical problems and for suicide (Yoder, Hoyt, & Whitbeck, 1998) and depression (DiPaolo, 1997), prostitution (Pennbridge, Freese, & Mackenzie, 1992; Yates et al., 1988), and drug use (Booth, Zhang, & Kwiatkowski, 1999; Pennbridge et al.; Ryan, Kilmer, Cauce, Watanabe, & Hoyt, 2000; Stefanidis et al., 1992; Whitbeck, Hoyt, & Ackley, 1997). These risks carry great implications for public health and social policy, as well as probable courses of action regarding interventions in the treatment of homeless and runaway adolescents.

Defining homeless and runaway youth. California, New York, and Boston seem to attract a disproportionately high number of disadvantaged youth who carry the label runaway. Also referred to as unaccompanied youth, these individuals may have left home due to family problems or have been asked to leave home (throwaways) and frequently do not return, becoming homeless (GAO, 1989). Homeless and runaway youth commonly report a history of physical, emotional, and/or sexual abuse (Kufeldt & Nimmo, 1987) and have experienced multiple trauma (DiPaolo, 1997) that is both extrafamilial and intrafamilial (Dadds, Braddock, Cuers, Elliott, & Kelly, 1993).

The majority (55%) of the 1.5 million homeless youth in the U.S. are male, and the majority (65%) of runaways are female (GAO, 1989). At federally funded shelters in 1987, 21% of the youth were listed as homeless (or throwaways), and 79% were listed as runaways. Homeless youth were typically

older than runaways, and 60% of the homeless population were over the age of 17 years. Older homeless youth were living in unstable situations with friends, on the streets, or in runaway houses. Half of the homeless youth who were 16 years of age or older had been expelled, been suspended, or dropped out of school. For all ages, 37% of homeless youth and 27% of runaways were not attending school. Ninety-three percent of runaways had been living with their parents or were in foster care prior to leaving home. Less than 10% had lived in families requiring public assistance (e.g., food stamps, public housing). The primary problem indicated by these runaway youth was a relationship with a parent. Other reports centered around problems such as alcohol and drug abuse, family mental health problems, death of a parent, hospitalization of a parent, parental disability or unemployment, physical and/or sexual abuse, or violence in the home (GAO, 1989).

Economics. Kufeldt and Nimmo (1987) conducted a study of the street economy and the street welfare system in Calgary, Canada, and their findings served as the impetus for opening a local safe house for homeless and runaway youth. The researchers interviewed 800 homeless and runaway youth who fit into one of two distinct groups. The ages of the youth ranged from 12 to 17 years. One group, designated as "in and outers," were running as a temporary coping mechanism. Their "runs" tended to be impulsive and short in duration. "True runners," however, had left their homes for an extended period with no

intent to return. The longer these runners were on the streets, the greater the likelihood that they would be approached to participate in illegal activities.

Findings revealed that those who had experienced physical or sexual abuse were more likely to run than youth who had not experienced abuse. Not all runaways, however, ended up on the streets. Thirty-six percent of those who had been residing with both biological parents ran to the street, yet a larger percentage (71%) of adopted youth did so. Children of single parents were slightly more likely to go to a relative's or friend's home, and those who were adopted or had been with both biological parents were least likely to go to a relative (Kufeldt & Nimmo, 1987).

Kufeldt and Nimmo's (1987) study also revealed a "street welfare system" that consisted of a combination of involvement in illegal activities (e.g., panhandling, begging; 1% of runners, 2% of in-and-outers), employment (7% of runners; 9% of in-and-outers), utilization of social services (6% in both groups), family assistance (20% of runners; 12% of in-and-outers), and "helpful" friends (55% of runners, 46% of in-and-outers). In short, the homeless and runaway youth were an underserved population, and a significant number of these individuals were on the street due to self-reports of systemic abuse and neglect that had occurred within substitute care arrangements.

Health status. Alone and without the assistance of social services, the health of many homeless and runaway youth has become a serious concern. A

study of the overall health status of runaways took place in Hollywood, California. The sample included 765 youth (age range = 10-24 years) who had visited an ambulatory service operated cooperatively by the Children's Hospital of Los Angeles, Division of Adolescent Medicine, and the Los Angeles Free Clinic. One hundred ten youth were runaways, and 655 were nonrunaway youth. Sixty-five percent of the runaways were Caucasian, 15% were Black, 10% were Hispanic, 3% were Asian, 2% were Native American, and 4% were of unknown ethnicity. Thirty-nine percent of the nonrunaways were Caucasian, 33% were Black, 20% were Hispanic, 5% were Asian, 1% were Native American, and 2% were of unknown ethnicity. Seven percent of the runaways were ages 10 to 14 years, 45% were ages 15 to 17 years, and 40% were ages 18 to 21 years. Six percent of the nonrunaways were ages 10 to 14 years, 28% were ages 15 to 17 years, and 57% were ages 18 to 21 years (Yates et al., 1988).

Participants were given the Children's Hospital High Risk Interview that included the following domains: home, education, activities, affect, drug use, sexuality, and suicide. Thirty-eight percent of the runaways reported that they were living on the streets and finding shelter in abandoned buildings, 10.9% resided with parents or relatives, 36.4% lived with friends, and 7.3% lived in a shelter. Sixty-seven percent of the nonrunaways lived with parents or relatives, 28% lived with friends, 0.8% lived in a shelter, and 0.2% lived on the streets (Yates et al., 1988).

Five times as many runaways as nonrunaways had dropped out of school. Eighty-four percent of the runaways used drugs or alcohol, and 34.5% had used intravenous drugs. Only 3.7% of the nonrunaways used drugs. More runaways than nonrunaways had engaged in survival sex (26.4% vs. 0.2%), had been sexually abused (21.8% vs. 5.2%), and/or had been physically abused (16.4% vs. 2.1%). More runaways than nonrunaways reported a first sexual experience between 10 and 14 years of age (38.2% vs. 11.6%) or at the age of nine or younger (19.1% vs. 2.1%). Fewer runaways than nonrunaways described themselves as heterosexual (82.7% vs. 84.7%), undecided (0% vs. 2.4%) or of unknown sexual orientation (0.2% vs. 5.3%). More runaways than nonrunaways described themselves as homosexual (7.3% vs. 4.9%) or bisexual (9.1% vs. 2.6%). Runaways were more likely than nonrunaways to be depressed (83.6% vs. 24.0%), to have previously attempted suicide (18.2% vs. 4.0%), to be actively suicidal (9.1% vs. 1.8%), or to have a mental health problem (18.2% vs. 3.8%). Whether the experiences reported by runaway youth occurred prior to their running away was unknown, and the nature of the mental health problems was not specific (Yates et al., 1988).

Prostitution. Runaways often engage in prostitution or "survival sex" in order to support a drug habit or simply to pay for food or shelter (Kipke et al, 1995; Yates et al, 1988), which may result in further complications in mental and physical health. According to a report presented at an annual meeting of the

American Psychological Association, studies of homeless and runaway youth reveal that 29.7% had been paid for sex and 22% had exchanged sex for food or shelter. Gay and lesbian homeless and runaway youth comprised 65% to 70% of youth needing services at the Los Angeles Gay and Lesbian Service Center's Youth Services Department. Eighty-eight percent were young men between the ages of 18 and 23 years, and 17% were between the ages of 13 and 17 years. The Children's Hospital of Los Angeles indicated that 72% of males involved in survival sex identified themselves as gay or bisexual. To make matters worse, homeless and runaway youth are often doubly victimized by sexual and aggravated assault, and their perpetrators are street peers and exploitative adults (Whitbeck & Simons, 1990).

At-risk for HIV/AIDS infection. One-quarter of all new HIV infections in the U.S. occur among persons under the age of 2 years, and over half occur among those under the age of 26 years (Office of National AIDS Policy, 1996). AIDS is the sixth leading cause of death in people who are between the ages of 15 and 24 years (Brown, Lourie, & Pao, 2000). Based on a study of 12 European nations, there is a dramatic increase of HIV/AIDS among heterosexuals who are less than 15 years old (Houweling et al., 1998, as cited in Brown et al., 2000). By the end of 1998, 3,423 AIDS cases among adolescents between the ages of 13 and 19 years had been reported by state and territorial health departments to the Centers of Disease Control and Prevention in the United States. Homeless and

runaway youth have HIV infection rates that are as much as 15 times the rate found in other adolescent samples. In New York City, 5.3% of the homeless and runaway youth are infected, and 6.5% of those in San Francisco are infected (D'Angelo, Gegso, Luben, & Gayle, 1991, as cited in Stricof, Kennedy, Nattell, Weisfuse, & Novick, 1991; Quinn et al., 1988, as cited in Stricof et al., 1991).

Stricof et al. (1991) initiated a study designed to (a) assess HIV seroprevalence among adolescents receiving health care at Covenant House New York, (b) ascertain demographic characteristics, (c) assess trends in seroprevalence over time, and (d) determine the risk factors associated with HIV infection in this population of youth. Covenant House New York, which serves adolescents under the age of 21 years, has a crisis center that accommodates more than 300 individuals each night, a drug treatment program for 26 residents (30-day average stay), a mother-child shelter, an outreach program, and a long-term transitional living program. Over a 27-month period between the fall of 1987 and the winter of 1989, 2,667 homeless and runaway youth (age range = 15-20 years) participated in this study. Each had undergone a medical evaluation and had been seen by Covenant House medical doctors for annual or follow-up visits.

A study test requisition form was completed by clinic staff that contained the age, race or ethnicity, gender, most recent county and zip code of residence, and month and year of specimen collection. No personal identifiers were

recorded. A risk assessment component was added to the study design one year after the study had begun. Information was documented in the medical record and abstracted onto a separate risk assessment form with the blind seroprevalence number, including gender of sex partners, history of intravenous drug use, crack use, prostitution, blood transfusion, and/or sexually transmitted diseases, as well as the sex partners' history of drug use, homosexual/bisexual activity, or HIV status (Stricof et al., 1991).

Overall HIV seroprevalence rates were calculated by quarter year of clinic visit. Further chi-square tests for trend were applied to the data, the effects of demographic characteristics were assessed by multiple regression analysis, and a univariate analysis for risk factors associated with HIV infection was performed with odds ratios and confidence intervals. Categories were established for intravenous-drug-using homosexual/bisexual males, intravenous drug users, blood transfusion recipients, persons with sex partners known or at risk for infection, persons with a history of sexually transmitted disease, prostitution, and crack users. Participants reporting no risk factors within these categories formed the reference group (Stricof et al., 1991).

The sample included 399 non-Hispanic Whites, 6.0% of whom were HIV positive. Blacks totaled 1,448 youth, 4.6% of whom were HIV positive. Of 688 Hispanic youth, 6.8% were HIV positive. Participants included 1,037 female adolescents (4.2% HIV positive) and 1,611 male adolescents (6.0% HIV positive).

One hundred nine (27%) reported that they were homosexual or bisexual, 24.8% of whom were HIV positive. Of the 12 intravenous drug users who were tested, 33.3% were HIV positive. Two hundred fourteen youth reported crack use, and 5.1% of those individuals tested positive for HIV. Sixty-nine youth had sexually transmitted diseases (STDs), and 4 of them (5.8%) were diagnosed with HIV infection. In the category with no indicated risk ($n = 576$) youth, 1.2% (6) were HIV positive (Stricof et al., 1991).

Intravenous drug use, a sex partner at-risk, and prostitution yielded the highest percentages of young women who were HIV positive. One hundred twenty-four young women had STDs, 6.4% of whom were also HIV positive, whereas 2.9% of the 69 who admitted using crack users were HIV positive. Of the 483 who indicated no risk for infection, 1.7% were diagnosed as HIV infected (Stricof et al., 1991).

Over time, HIV seroprevalence tended to decline for women ($p = 0.06$), Blacks ($p = 0.08$), and 19- to 20-year-olds ($p = 0.09$). When all other demographic variables were controlled for, age was found to be associated with HIV seropositivity, and seroprevalence rates ranged from 1.3% for 15-year-olds to 8.6% for 20-year-olds. Of 312 tested at ages 15 to16 years, 2.2% (7) tested positive for HIV. Of 340 tested at age 17 years, 2.9% (10) tested positive. Of 591 tested at age 18 years, 3.4% (20) tested positive; and 6.5% of 750 tested at age 18 years tested positive. Of 563 individuals tested at age 20 years, 9.86% were identified

as HIV positive. Of a total of 2,667 specimens analyzed, 142 youth were found to be HIV positive. For men the prevalence rate was 6%; for women it was 4.2%. (Stricof et al., 1991).

Risk assessment forms were eventually submitted for 1,758 young people (1,039 men, 719 women). HIV infection in men was associated with intravenous drug use, homosexual/bisexual activity, history of a sexually transmitted disease, prostitution, and crack use. HIV infection in women was associated with a history of other sexually transmitted diseases (Stricof et al., 1991).

Kipke et al. (1995) conducted a study of youth (age range = 12-23 years) who had been living on the streets of Hollywood, California, without family for two or more consecutive months and were members of the street economy (i.e., engaging in street prostitution or survival sex, pornography, panhandling, stealing, selling stolen goods, mugging, dealing drugs, scams/cons). These individuals provided self-reports of drug use and involvement in other behaviors that placed them at risk for infection for the human immunodeficiency virus (HIV). Four hundred nine participants were recruited by means of a stratified probability sampling design (i.e., probability of selection was proportional to the estimated unduplicated number who use each service monthly). One sampling frame was developed for fixed service sites (e.g., shelters, drop-in centers) and another for natural street sites (e.g., parks, alleys, bars, fast-food restaurants). Three shelters and six drop-in centers were

randomly selected, which the researchers speculated would reach nearly half of Hollywood's homeless and runaway youth.

Participants were randomly selected from a sign-in roster and asked to respond to a 12-item screening instrument that determined their eligibility for the study. Those who qualified were given the Acquired Immunodeficiency Syndrome Evaluation of Street Outreach Project Street Intercept, a 15- to 20-minute structured interview developed for the Centers for Disease Control and Prevention's Acquired Immunodeficiency Syndrome Evaluation of Street Outreach Cooperative Agreement Project. This survey was designed to assess the respondent's involvement in sexual and drug use behaviors related to HIV risk, contact with outreach workers, and/or use of shelters and drop-in services (Kipke et al., 1995).

Data were collected in January and February (n = 203) and May and June (n = 204) of 1993. Six hundred thirty-two adolescents were approached, 499 were screened, and 133 (21%) refused, citing the most common reason of "too busy" hustling or dealing drugs. Youth between the ages of 19 and 23 years had the highest refusal rate (28%, $p < .003$), 16 to 18-year-olds had a refusal rate of 16%, and 12 to 15-year-olds had a refusal rate of 12%. An incentive ($3 in food vouchers) was offered for completing the 12-item screening instrument, and an additional incentive ($7 in food vouchers) was offered for completing the Street Intercept Survey (Kipke et al., 1995).

The researchers found no significant differences between the data in each of the two 2-month periods, so all data were aggregated into one set. Logistic regression analysis was conducted to determine which sexual risk behaviors were predictors of drug use category: High Risk High Dependency (HRHD) and Low Risk Low Dependency (LRLD). A univariate model was used as a single predictor of drug use. To control for confounding of demographic variables, a multivariate logistic model was used with age, gender, race, sexual orientation, and length of time homeless as covariates (Kipke et al., 1995).

Nearly all participants (79%) reported some alcohol use, and 50% reported having used alcohol during the previous week. Among alcohol users, the use of other drugs was also reported: 55% had used marijuana, 62% had used methamphetamine or speed, and 38% had used crack cocaine within the previous 30 days. Other drugs commonly used included cocaine, LSD, and heroin. Sixty-five percent of the drug use was in the HRHD (High Risk, High Dependency) category, 16% was in the HRLD (High Risk, Low Dependency) category, and 55% was in the LRLD (Low Risk, Low Dependency) category. High-risk sexual and drug use behaviors were significantly intercorrelated. Youths in the HRHD and HRLD categories were 2.9 times more likely than those in the other categories to self-report having had multiple sexual partners (50% and 24%, respectively; $p < .001$; Kipke et al., 1995).

One limitation of this study, admitted by these researchers, is its primary dependency on self-reports that may underestimate the prevalence of high-risk behaviors (Kipke et al, 1995). Another concern is the use of probability sampling techniques that may limit the generalizability of these findings to street youth populations in other cities.

Suicidality. The multiplicity of risk-related behaviors in which runaways engage may culminate in a reduction of coping responses, thereby adding the risk of suicide (Rotheram-Borus, Koopman, & Ehrhardt, 1991). Runaways have been found more likely to be depressed, more likely to have attempted suicide, more likely to be actively suicidal, and more likely to have serious mental health problems (Yates et al., 1988). Homeless and runaway youth who tend to internalize their depression and have been sexually abused are more likely to engage in suicide attempts than are those who internalize their depression and use drugs as a coping strategy (Yoder et al., 1998). Homosexual youth who have attempted suicide have been shown to be more likely than homosexual youth who have not attempted suicide to have had a first sexual experience before 14 years of age (Schneider, 1989, as cited in Kruks, 1991). Sexually victimized homeless and runaway youth have also been more likely than those were not sexually victimized to attempt suicide (Yoder et al.).

Attachment Research With Homeless and Runaway Youth

There has been a paucity of research examining the etiology of runaway behavior, the psychological problems that result from life on the streets, and the cumulative effects of early child development and attachment history for homeless youth. Four studies that were conducted from an attachment perspective on issues ranging from stabilization to suicidality and from personality traits to psychopathology will be reviewed. Stefanidis et al. (1992) explored the effects of attachment history on efforts to stabilize homeless and runaway youth, whereas Adam, Sheldon-Keller, and West (1996) studied attachment organization and suicidality. Rosenstein and Horowitz (1996) examined the relationships among attachment classification, personality characteristics, and psychopathology, and Allen, Hauser, and Borman-Spurrell (1996) examined severe adolescent psychopathology in the context of attachment theory.

Effects of attachment history on runaway youth. Seeking a greater understanding of this population, Stefanidis et al. (1992) conducted a study of the Los Angeles Youth Network (LAYN) over a 6-month period. The researchers worked with 60 adolescents (age range = 12-17 years, M = 16.6 years) to compare the correlation between their attachment histories and their ability to leave street life and transition into stable living conditions. A control group was comprised of 20 youth who had been off the streets for 6 months, and the

experimental group was comprised of 40 residents of the LAYN shelter. The experimental group was then separated into two subgroups: Stabilization-Response (SR) and Stabilization-Nonresponsive (SNR). The SR group was comprised of former runaways who were currently living independently, in a foster care or institutional placement, or with their own families.

Stefanidis et al. (1992) administered a semistructured interview, the Attachment History Questionnaire (AHQ; Kessler & Pottharst, 1983, as cited in Stefanidis et al., 1992), and the Separation Anxiety Test (Hansburt, 1972, as cited in Stefanidis et al., 1992) to each participant. Both instruments are compatible with the constructs presented in Bowlby's (1969/1982, 1980) attachment theory emphasizing the importance of early caregiver-child interactions. The AHQ is a self-report inventory that assesses basic areas of family life, interactions reflecting the attachment process, and disruptions in the attachment process. The Separation Anxiety Test requires that respondents select one of a variety of responses after evaluating each of 12 drawings that portray common separation situations of childhood and adolescence.

Results indicated that those in the SR group had more positive attachment histories and were able to move off the streets and reintegrate into society, whereas those in the SNR group had less positive attachment histories and were less able to reintegrate into society. A discrimant function analysis indicated that the control (stabilized) group and the SR group were similar

regarding attachment histories, and both were significantly different from the SNR group. Members of the control and SR groups reported fewer previous placements in foster care and more positive attachment experiences than did those in the SNR group, F (2, 58) = 10.20, $p < .0006$. The control group also indicated a greater propensity towards wanting others' care and attention than did the SNR group (Stefanidis et al., 1992).

Further analyses indicated that those in the SNR group were less engaged with caregivers than were those in the control group, t (19) = 3.30, $p < .004$. Those in the SR and control groups provided more appropriate responses to emotionally charged situations than did those in the SNR group. The SNR group revealed a significantly greater capacity to adopt an inappropriately uninvolved stance towards their homelessness and towards those who were attempting to help them, F (2, 58) = 13.87, $p < .0001$ (Stefanidis et al., 1992).

Both control and SR youths showed higher levels of depression than did the SNR youths, F (2, 58) = 5.80, $p < .0005$. This finding suggests that adolescents in the SNR group were less concerned and less attached to the staff and to one another, less able to access their feelings, and appeared to have defense mechanisms that allowed them to deny feelings in order to survive. The SNR group exhibited a capacity to exaggerate feelings of well-being and consequently appeared less motivated to change their behavior. They mocked

other youth who sought help from staff and refused interventions for themselves (Stefanidis et al., 1992).

Although this study is limited methodologically because data was collected differently in the comparison groups, these findings carry implications for service providers of homeless and runaway youth. These youth clearly had differing expectations. SNR youths expected that fewer people would be available to them and that others would be less willing to help did SR youths. Furthermore, SNR adolescents had histories filled with experiences of rejection and maltreatment. They were mistrustful of close relationships and terrified of allowing themselves to rely on others. They often rejected help that was offered out of their fear of rejection (Stefanidis et al, 1992).

Attachment organization and suicidality. As stated earlier, the multiplicity of risk-related behaviors of homeless and runaway youth may diminish coping responses, thereby increasing the risk of suicide. Adam et al. (1996) conducted a study of 133 adolescents (44% female, 56% male) who were receiving psychiatric treatment in three Canadian cities. A case-comparison explored the association between attachment patterns and suicidality. Sixty-nine adolescents (53 with histories of suicidal behavior, 16 with histories of suicidal ideation) were in the case group, and 64 adolescents who had never experienced suicidal ideation or behaviors were in the comparison group. The case and comparison groups did not differ significantly in regard to racial composition

(87% and 86% White, respectively). However, more of those in the case group were in residential treatment (64% vs. 44%) and more were female (54% vs. 34%) than were those in the comparison group. Members of the case group were also older than members of the comparison group ($\underline{M}$ = 15.7 years and 14.9 years, respectively).

The Youth Self-Report (YSR) behavior checklist and the Teacher Rating Form were administered, as well as Adam's Suicidal Ideation and Behaviors protocol, which relies on inquiries into lifetime suicidal ideation (e.g., frequency, intensity, duration, periods of occurrence, history of suicide attempts). The AAI was also included, but wording was modified on some questions in order to be better understood by the adolescent population. Adam et al. (1996) also paid close attention to severe separation experiences (e.g., being asked to leave home, having been placed in foster home or institutional care). Each AAI was audio taped, and transcripts were scored on 9-point scales. Five scales rated early experiences with attachment figures, six rated current state of mind related to attachment, and two scales rated evidence of unresolved-disorganized loss and abuse related to attachment. Two additional scales rated evidence of the subject's coherency, one was rated with respect to coherency of the discourse, and a final scale was rated for overall coherency of mind. Attachment classifications were determined using the Main and Goldwyn (1994) scoring manual (as cited in Adam et al., 1996).

Findings indicated that attachment-related trauma had been experienced by 86% of the case group and by 78% of the comparison group. The most frequent attachment style among those in the case group (history of suicidality) was a pattern combining unresolved-disorganized and preoccupied attachment. This pattern was considered the most severely disturbed level of attachment (40% of male patients, 30% of female patients). The most frequent attachment style for male patients in the comparison group (no history of suicidality) was dismissing (45%), whereas the most frequent attachment style for female patients in the comparison group was autonomous (27%). Seventy-one percent of those in the case group and 29% of those in the comparison group who had experienced abuse were classified as unresolved-disorganized. Patients with histories of suicidality were strongly associated with early attachment traumas and an unresolved-disorganized/preoccupied attachment style. However, male patients without a history of suicidal behaviors or ideations tended to have dismissing styles, whereas female patients without a history of suicidality tended to have autonomous attachment styles (Adam et al., 1996).

Attachment classification and psychopathology. Rosenstein and Horowitz (1996) used the AAI to assess the relationship between attachment insecurity and increased symptomatology with a sample from an inpatient (psychiatric) adolescent population and provided a concurrent assessment of maternal and adolescent attachment organization. They hypothesized the

existence of continuity of mental organization of attachment throughout the lifespan as well as between generations, expecting to find a high correspondence between adolescent and maternal attachment classifications. They also explored the relationship between specific forms of adolescent psychopathology and attachment styles.

The sample included 32 male patients and 28 female patients (age range = 13.08-19.75 years; M = 16.36 years) admitted to a private psychiatric hospital and 27 patients' mothers. Ninety-five percent of the participants were Caucasian, 45% were from intact families, 37% were from single parent families, and 18% were from blended families (Rosenstein & Horowitz, 1996).

Patients completed diagnostic and personality assessments, and both the adolescents and their mothers completed the AAI. The Structured Clinical Interview for Diagnosis-Patient version (SCID-P) and previous records were used to determine diagnoses. The psychological test battery included objective and projective personality tests, screening for organic impairment, and a test of intelligence; the Wechsler Intelligence Scale for Children-Revised for patients under 16 years of age or the Wechsler Adult Intelligence Scale-Revised for those 16 years of age and older (Rosenstein & Horowitz, 1996).

Intelligence data included Verbal, Performance, and Full Scale scores. Verbal IQ scores ranged from 77 to 141 (M = 102.75, SD = 14.36) Performance IQ scores ranged from 68 to 134 (M = 104.51, SD = 15.50), and Full Scale IQ scores

ranged from 74 to 134 (M = 103.73, SD = 14.33). Psychiatric diagnoses included conduct disorders (CD; including oppositional defiant disorder), affective disorders (AFF; including major depression, dysthymic disorder, and schizoaffective disorder), and substance abuse (SA; Rosenstein & Horowitz, 1996).

The match between SCID-P and psychological testing diagnoses was 71% for CD, 79% for AFF, and 58% for CD plus AFF. Of the 60 adolescent patients, 55% had AFF diagnoses; 13% had CD diagnoses; and 20% had AFF and CD diagnoses. Two patients had an anxiety disorder, and 12% did not fit into any of the three categories. One patient had a SA, one was diagnosed with attention deficit disorder, two were diagnosed with atypical psychoses, and one was diagnosed with a multiple personality disorder. One-half of the 60 patients had a comorbid SA diagnosis. Additional data were collected on 51 patients who had refused participation, and their diagnoses were as follows: Twelve percent had CD diagnoses, 45% had AFF diagnoses, and 16% had AFF and CD diagnoses. The diagnostic distribution was fairly close between the two groups except for an overrepresentation of psychotic disorders (16%) and personality disorders without an Axis I diagnosis (19%) among those in the nonparticipant group (Rosenstein & Horowitz, 1996).

The psychological battery included the Millon Clinical Multiaxial Inventory (MCMI; Millon, 1983, as cited in Rosenstein & Horowitz, 1996), the

Symptom Checklist-90-Revised (SCL-90-R), and the AAI. The MCMI is a 175-item self-report inventory that has proven useful in diagnosing personality disorders and characteristics. Its 20 subscales have proven high test-retest reliability, and mean correlations across personality scales have been .73 (Overholser, 1990, as cited in Rosenstein & Horowitz, 1996). The SCL-90-R is a survey of symptoms typically reported by medical and psychiatric patients. Internal consistency coefficients (Cronbach's alpha) and split-half reliabilities (Spearman-Brown) for this scale have been reported as .98 (Hoffman & Overall, 1978, as cited in Rosenstein & Horowitz).

AAI transcripts were scored and kappa agreement on classifications for this study was .540. AAI data were analyzed twice: (a) using a four-category model and (b) using a three-category model that excluded the unresolved category. Results using the four-category model were as follows: 2% of the patients were autonomous, 38% were dismissing, 42% were preoccupied, and 18% were unresolved. Results using the three category model were as follows: 3% of the patients were autonomous, 47% were dismissing, and 50% were preoccupied. The use of either model yielded findings that indicate high rates of insecure attachment among psychiatrically ill adolescents (Rosenstein & Horowitz, 1996).

Although the relationship among intelligence, attachment, gender, and diagnosis remained statistically insignificant, chi-square analyses revealed

significant associations between attachment and Axis I diagnosis using either the four-category or the three-category attachment models. CD was associated with a dismissing attachment; however, patients with concurrent CD and AFF were unlikely to have a dismissing classification. Unresolved attachment was associated with AFF with or without comorbid CD (Rosenstein & Horowitz, 1996).

The SA group was almost twice as likely to demonstrate a dismissing organization as the non-SA group. The associations among SA, other Axis I diagnoses, and attachment classification were significant using either the four-category or three-category models, χ^2 (6, $\underline{N}$ = 29) = 14.752, $\underline{p}$ < .022. In the SA group, those with CD were strongly associated with the dismissing classification, as were participants with comorbid CD, AFF, and SA. Participants with AFF and SA were split between preoccupied and dismissing classifications, and SA was not as strong in predicting dismissing attachment as was CD (Rosenstein & Horowitz, 1996).

Significant gender differences were found both in attachment classification and diagnosis using a series of likelihood ratio chi-square analyses. Neither male nor female patients were favored in the unresolved category, the fourth category was dropped, and gender was analyzed using the three-category model. Male adolescents were significantly more likely to be dismissing than to be preoccupied (66% vs. 34%), as well as more likely than

female adolescents to be dismissing (75% vs. 25%). Female adolescents were more likely to be preoccupied than to be dismissing (68% vs. 25%) as well as more likely than male adolescents to be preoccupied (63% vs. 37%). The only two participants classified as autonomous were female. This pattern of gender differences is consistent with other studies of adolescents or pathological populations using the AAI (Kobak & Sceery, 1988, as cited in Rosenstein & Horowitz, 1996). Twice as many male patients had an SA diagnosis, whereas female patients showed high rates of AFF alone, and male patients showed a higher likelihood of CD. The most common diagnosis for all participants was AFF. Male patients' attachment classifications were significantly related to diagnoses and frequently paralleled as follows: (a) CD and dismissing attachment, (b) AFF alone with dismissing or preoccupied attachment, and (c) AFF with preoccupied attachment (Rosenstein & Horowitz).

A relationship was found between specific personality disorders and an attachment classification. Adolescents with a dismissing attachment organization were more likely to have a conduct or substance abuse disorder, a narcissistic or antisocial personality disorder, and self-reported narcissistic and antisocial personality traits. Adolescents with a preoccupied attachment were more likely to have an affective disorder, obsessive-compulsive, histrionic, borderline or schizotypal personality disorder, and self-reported avoidant, anxious, and dysthymic personality traits. Results were inconclusive when the

relationship between personality traits and attachment classification was examined. Self-acknowledged symptomatic distress was a weak discriminator between attachment groups.

Analysis of the relationship between Axis II diagnoses and attachment classifications revealed that 24 patients (40%) had Axis II diagnoses as well as Axis I AFF diagnoses. Although the number of patients with other Axis II diagnoses were generally insufficient for statistical analysis, borderline personality disorder occurred in 14 of the 24 patients, the majority of whom were female and more likely to be preoccupied (64%) than dismissing (29%; Rosenstein & Horowitz, 1996).

AAI classifications for the adolescents' mothers revealed that 2 were autonomous, 4 were dismissing, 10 were preoccupied, and 11 were unresolved. Rosenstein and Horowitz (1996) stated that this consonance between adolescent and maternal attachment classification lends support to Bowlby's (1973) claim that styles of adaptation and defensive bias arise in the context of mother-child interaction. Maternal behavior is a function of the mother's mental organization of attachment experiences, and her attachment patterns are internalized by the child and maintained by defensive biases and continuous interaction with the mother. If an adolescent's psychopathology alone were influencing current mental organization, then a corresponding maternal attachment would not be expected.

Attachment theory and severe adolescent psychopathology. Children with disorganized attachment patterns have no coherent strategy for responding to separation or reunion. Since internal working models are based on a child's experience, behavior, and the responses of a caregiver or attachment figure, the insecurely attached child is vulnerable to fragmentation or incoherence, potentially producing a multiplicity of inconsistent internal working models. Some of these internal working models may remain unconscious as a result of defensive efforts to disavow painful affect caused by the attachment figure's incompetence (Bowlby, 1973).

In addition to the reported concordance between adolescent and maternal attachment patterns (Rosenstein & Horowitz, 1996), a similar connection between insecure attachment to caregivers and the risk of adolescent psychopathology seems apparent (Allen et al., 1996). The efficacy of treatment with severely disturbed adults is much lower for those with insecure attachment organizations (Dozier, 1990, as cited in Allen et al., 1996), and adult attachment organization may play an important role in mediating the transmission of psychopathology across generations (Cummings & Cicchetti, 1990, as cited in Allen et al.). With these thoughts in mind, subtypes of insecure attachment may be related to severe psychopathology. In fact, unresolved attachment organizations in adulthood may reflect a major loss or trauma that overwhelmed the individual and his or her capacity for attachment (Main &

Hesse, 1990, as cited in Allen et al.). Such traumatic attachment experiences may have become incorporated into distorted models of relationships that affect perceptions and expectations of future relationships in ways that become self-perpetuating and self-fulfilling (Alexander, 1992, as cited in Allen et al.). Since insecure attachment organizations are purported to be the result of previous difficulties, adults' defensive dismissal of the importance of attachment relationships may proliferate both severe adolescent pathology and adult symptoms that have been linked to negative expectations about relationship.

Allen et al. (1996) examined the long-term sequelae of severe adolescent pathology within the framework of attachment theory. Participants had been admitted to a private psychiatric hospital when they were 14 years old and were included in a follow-up study 11 years later. Data were compared with a similar sample of adolescents recruited from a nearby public high school. The researchers explored the following issues: (a) Does severe psychopathology in adolescence predict insecurity in young adults' attachment organization, and if so, can particular types of insecure attachment organization be predicted? (b) Is adult organization linked to current pathology, and could such a linkage account for the relation between previous severe psychopathology and current signs of pathology? and (c) Are there observable continuities between specific diagnoses in adolescence and attachment organization or signs of pathology in young adulthood?

One hundred forty-two (71 female, 71 male) adolescents participated in the original study. Seventy-six were 9th-graders at a public high school, and 66 had been recently psychiatrically hospitalized ($\underline{M}$ = 14.4 years). Ninety-seven percent of the original sample participated in the follow-up study 11 years later. Among those who had been hospitalized, 21% were diagnosed with oppositional defiant disorder, 19% had a conduct disorder, 19% had major depression, 18% had other mood disorders, and 33% had other (unspecified) disorders. Those with depression and mood disorders were included in an internalizing disorders group (29%), and those with conduct and oppositional defiant disorders were included in an externalizing disorders group (41%). There was a 92% agreement between diagnoses at age 14 years and at age 25 years for the hospitalized groups. Adolescents in the hospitalized groups and the control (public school) group did not differ significantly in age, gender, birth order, or number of siblings. Although they differed slightly in social class (the control group was of a higher socioeconomic status [SES] than the hospitalized groups), all groups were in the upper-middle-class-range (Allen et al., 1996).

Participants completed the AAI, the SCL-90-R, and the Global Self-Worth scale from the Adult Self-Perception Scale, (Messer & Harter, 1986, as cited in Allen et al., 1996). Criminal behavior was indicated by the total number of times an adolescent reported participating in each of 30 classes of illegal behavior (nonoverlapping except for drug use) over the past 6 months. Hard drug use

was indicated by the total number of instances of illicit use of each of five classes of hard drugs (heroin, cocaine, hallucinogens, amphetamines, and tranquilizers) in the previous six months.

Adolescent psychopathology severe enough to warrant hospitalization was strongly predictive of insecure attachment organization 11 years later. A chi-square analyses assessed the relation between previous hospitalization and overall attachment classification. Subsequent chi-square tests were used to determine whether individual AAI classifications differed in their relation to prior hospitalization. Substantial differences among young adult classifications were found between the previously hospitalized and control groups. When all five possible classifications were considered (secure, insecure-preoccupied, insecure-dismissing, insecure-unresolved, cannot classify), 44.7% of the high school sample were classified as secure in young adulthood, whereas only 7.6% of the previously hospitalized sample were secure in young adulthood (Allen et al., 1996).

A multivariate analysis of variance (MANOVA) determined the relationship between prior psychiatric hospitalization and adult attachment organization by examining scales for specific states of mind regarding attachment in young adulthood, which revealed a significant overall relation to previous psychiatric hospitalization, F (8, 89) = 3.76, $p < .001$. Previously hospitalized participants displayed less ability to describe previous attachment

experiences in a clear, consistent manner than did the control group. Previous hospitalization was also associated with high levels of derogation of attachment relationships, insistence on inability to recall attachment experiences, and indications of lack of resolution of previous trauma. However, neither gender nor SES were overall predictors of states of mind regarding attachment (Allen et al., 1996).

Demographic factors, previous hospitalization, and states of mind regarding attachment added to the prediction of self-reported criminal behavior and use of hard drugs among young adults. Results also indicated an association between overall attachment organization and young adult psychopathology. Young adults with dismissing attachment organizations reported significantly more criminal behavior than did secure adults, and those with cannot-classify AAI transcripts displayed higher levels of criminal behavior and psychological distress and lower levels of self-worth than did adults with secure classifications. Young adult criminal behavior was also related to lack of resolution of previous trauma (Allen et al., 1996).

Foundations of Treatment

The theory of attachment as a secure-base relationship integrates insights about affect, cognition, and behavior in close relationships across age and culture. Empirical research based on attachment theory supports these

important insights about the nature of infant-caregiver and adult-adult close relationships as well as the significance of early childhood experience, and about stability and change in individual differences. Views of attachment development, attachment representation, and attachment in family and cross-cultural perspective need to be updated in light of empirical research and advances in developmental theory, behavioral biology, and cognitive psychology. The theory also needs to be challenged by formulating and testing hypotheses and confirming what is already known about attachment theory (Waters & Cummings, 2000).

Homeless and runaway youth are speculated to have been involved in what they perceive to be an emergency situation at home to which they have responded in such a way as to be ejected from their homes or to have fled from their homes. The secure-base experience appears to have been unavailable during stressful family interactions. Overprotected children and adolescents who are not allowed to explore new environments may be responding to a perceived emergency situation where the separation-individuation developmental process is truncated. The emergency responses of running away or being ejected from a home environment communicate that a stressful situation is occurring and can no longer be organized within the family system.

Secure attachment occurs, not because there is an absence of emergency or crisis situations in a child's life, but because the primary caregiver provides a

secure base. From that secure base, the adolescent can form a supervision partnership that will help the adolescent organize experiences and work effectively. Most homeless and runaway youth report that they have suffered abominably at the hands of those who they believed would care for them. This situation has resulted in behavioral responses that are contrary to what would be expected if there is a secure base.

Traumatic attachment experiences become incorporated into distorted models of relationships, and these distorted perceptions and expectations of future relationships become self-fulfilling and self-perpetuating. In adolescence, insecure attachments have been linked to depression and behavior problems, and some evidence suggests that insecure attachments are linked to characterological disorders (DiPaulo, 1997). Even in consideration of long-term effects, current interventions are commonly focused on short-term solutions. Further research is needed to establish better long-term treatment models for homeless and runaway youth.

Short Term Intervention

Short term treatment models primarily focus on stabilizing the adolescent's environment. Stefanidis et al. (1992) purport that service providers trained in attachment theory offer increased sensitivity and improved relational skills to youth in crisis that are conducive to the beginning of a secure attachment relationship. Although these adolescents often appear to be involved

in an active and purposeful flight away from primary attachment relationships, theirs is not a healthy separation-individuation process, but an attempt to escape from intense conflict or severe abuse. Using effective attachment interventions, caregivers can appropriately respond to homeless and runaway adolescents' calls for support and protection and avoid the reenactment of their attachment histories.

In general, treatment models for homeless and runaway youth begin with short term crisis intervention while some programs also incorporate outreach to youth living on the streets. While many of these youth have participated in demographic studies, interventions typically begin when runaways leave the streets due to a severe crisis or are released from jail and subsequently enter shelters or drop-in centers (Yates, Pennbridge, Swofford, & Mackenzie, 1991; Rotheram-Borus et al., 1991).

Shelters allow for short-term interventions, education, and referrals to other resources (Grigsby, 1992; Yates et al., 1991). Often, youth will not cooperate with interventionists who suggest they move from a potential crisis situation to a more stable environment (Stefanidis et al., 1992). Brief counseling models are frequently based on social learning theory or have provided intensive education about HIV/AIDS (Tenner, Trevithick, Wagner, & Burch, 1998). However, attachment research suggests that long-term treatment would be more effective in achieving lasting change.

Goodman, Saxe, and Harvey (1991) cite the correlation between mental health and the stressors of being homeless. They suggest that trauma, learned helplessness, and attachment issues may exacerbate existing psychological disorders. Therefore, shelters and other programs for the homeless typically attempt to promote social connectedness and individuals' sense of personal empowerment by involving them in decisions that affect their daily lives. A safe environment facilitates social interactions and establishes peer support groups that will emphasize individuals' strengths as they reestablish familial and/or community relationships. Case management is also an essential component of short-term interventions that assist adolescents in negotiating the social services system. Immediate interventions continue to be part of child abuse reporting, suicide prevention, and drug or HIV education.

Mundy, Robertson, Robertson, and Greenblatt (1990) noted that homeless and runaway adolescents endorsed psychotic symptoms, often positively associated with indices of depression, which leave the homeless and runaway youth grossly incapacitated. Although a facility's purpose is to provide relief, it cannot provide all that is needed for dealing with the emotional impact of an adolescent's past and current attachment relationships. Brief counseling services may be provided; however, some youth choose not to participate. Others fear potential consequences of reporting their abusers to child protective services or to the police.

The longer brief treatment models whose underlying conceptual framework is social learning theory are considered intensive programs of about ten sessions in length addressing youth with HIV or HIV education and prevention. The goal is primarily behavior change. Although shelters and other facilities require that youth not be using drugs or alcohol, youth who do not return home after a 30-day stay or those for whom longer term shelter care (approximately 60 days) is unavailable are at risk to return to the streets and to their former patterns of high-risk behavior (Rotheram-Borus et al., 1991).

Long-Term Treatment

Shelters and other facilities providing models of treatment addressing the need for individual or group interventions appear not to be designed to address youths' need for longer term individual and family therapy. There is little research describing model long term treatment programs that specifically address the need for this type of treatment. Long term interventions are in general described as long term crisis shelter and case management (Grigsby, 1992; Yates, Pennbridge et al., 1991). Although therapy may be part of a shelter treatment program, it usually does not begin until after the youth has been placed in a stable environment. As yet, there appears to be little in the literature on the type and quality of longer term therapeutic intervention with homeless and runaway youth.

Short-term interventions are intended to address immediate crises, but may fail to result in lasting changes for homeless and runaway youth. Long-term treatment, however, allows time for the reevaluation of attachment relationships with caregivers and changes the focus from crisis intervention to the adolescent's active participation in a safe and secure environment that meets his or her need for attachment bonds. The use of AAI assessment can provide clinically relevant information and can be useful in helping these adolescents relate their experiences and begin the process of therapy. With a therapist serving as an attachment figure, adolescents may be able to return home to their parents or primary caregivers, who may, in turn, become more open to receiving treatment as well.

Kipke, Palmer, LaFrance, and O'Connor (1997) reported that homeless and runaway youth often viewed their primary attachment figures as authoritarian, autocratic, and nonresponsive, with little respect for them as independent decision-makers. Some described their parents as intrusive, emotionally unavailable, and detached. Others reported parents who had problems with substance use or the law. Levels of family conflict and distress within the home, the temperaments of family members, and parents' ability to make sense of their own early childhood experiences are crucial to the development of attachment security. Families that respond to stressful interpersonal interactions with aggression, violence, sexual, physical, and

psychological abuse require interventions aimed at helping them to confront the effects of their behavior and to stop the abuse. Further attachment research and long-term interventions are needed to assist these families in the development of rewarding attachment relationships that will preclude the desire to distance themselves through aggressive or self-destructive behaviors.

Obstacles to long-term treatment as an alternative to returning to the parental home include lack of funding, inadequate facilities, inefficient placement procedures, and the shortage of substance abuse programs and HIV support systems for adolescents. Youth may also exclude themselves from treatment to avoid rules and limit-setting.

Although certain provisions can be met through state and public services, the provisions of counseling and therapy on a consistent and long-term basis has been lacking. Further, the lack of privacy in shelters makes therapy difficult and, therefore, may not be the most effective mode of service delivery under current conditions. Other barriers include distance, expense, physical aspects (for the disabled), language, and cultural differences (Rosenberg, Solarz, & Bailey, 1991).

Due to the fact that comprehensive services are not available to adolescents in any one shelter, daily life in a shelter is often difficult (Rotheram-Borus et al., 1991). However, a collaborative model has been advocated as the best approach in working with homeless and runaway youth in order to

network and strengthen already existing services available to them. (Yates et al., 1991).

Summary and Conclusions

There are as many as 1.5 million homeless and runaway children and adolescents on the street in the United States, and there are 100 million homeless adolescents worldwide. Between 1991 and 1997, the number of children and adolescents serviced by the American government increased by 35% while the number of foster care homes decreased by 27% (Rotheram-Borus et al., 1991). Although many foster care providers attempt to offer a secure base for these children, foster children's actual experiences may be quite different and often leave them feeling unsafe and insecure. In general, most youth who have received services in shelters, or who have been placed in foster care do not return to their families of origin (GAO, 1989; Yates, Pennbridge et al, 1991). Nevertheless, advocated for minors who are homeless and runaway, when feasible, is the return of that minor to their parental home (Thompson, Pollio, & Bitner, 2000).

Whether or not adolescents return to their homes, the need for secure attachments remains and can be met, in part, through a long-term therapeutic relationship. Appropriate assessment of the individual's history and current patterns of attachment is essential for the development and implementation of

an effective treatment plan. A clinical interview and self-report instruments provide historical information regarding early and current attachment relationships as a part of treatment and intervention with these youth.

Many factors (e.g., prostitution, drug abuse, suicide attempts, HIV/AIDS) have been found to further complicate treatment that is provided for adolescents in runaway shelters. Since many states consider homeless and runaway youth to be emancipated minors, treatment plans vary and may or may not require family involvement. Medical care and, perhaps, neurocognitive assessments are crucial for some (e.g., those with HIV/AIDS), and some providers have advocated bypassing parental consent (Rotherum-Borus et al., 1991).

More extensive training for service providers is also advocated, as are manuals and educational materials that are specifically targeted at high-risk youth such as those who are involved in prostitution and/or drug use and those who have reported being victims of sexual abuse (Grigsby, 1992; Stefanidis et al., 1992).

The treatment of depression, characterological disorders, and sexual, physical, and psychological abuse has not been addressed in this review of the literature. There appears to be very little research on homeless and runaway youth that addresses long-term treatment provisions related to therapy and the best types of therapy for this population. The involvement of a psychologist in

the treatment of adolescents especially those diagnosed with HIV is advocated. Assisting in the organization of psychologically appropriate multidisciplinary treatment, attention to the mental health needs of providers, and advocacy efforts to address the psychosocial factors is advocated (Brown et al., 2000).

The lack of a supportive and functional family is the single largest factor associated with adolescent homelessness as found through the only national study utilizing self-reports of homeless and runaway youth conducted at privately funded shelters (GAO, 1989). However, others perceive that because family problems include parental substance abuse, family homelessness, health problems, and social isolation, it is believed that adolescents are often better served by leaving their homes rather than by remaining in situations that are abusive and where problems are unsolvable (Rotheram-Borus et al., 1991).

Longitudinal designs and independent ratings of adolescent and family problems rather than a self-report alone have also been suggested. The exploration of parental perceptions of the family process and children's adjustment following rejection from their homes or their willing departure have also been suggested. Furthermore, the targeting of family-adolescent relationships in the design of preventative programs and other community responses to adolescent homelessness will be important for future interventions that also require parent involvement (Dadds et al., 1993).

The utilization of the AAI based on a four-category model has been proposed as part of the treatment process with homeless and runaway youth. The instrument appears to be useful in the interview as a framework from which service providers might understand attachment issues. Due to the development of the AAI (Main et al., 1985), attachment in insecure adolescents and their parents can be studied and subsequently linked with adolescents' difficulties, interpersonally, and intrapsychically. Attachment throughout the life span and between generations is of primary importance in the psychopathology of adolescence. Hazan and Shaver's (1987, 1990) three-category model and Bartholomew and Horowitz's (1991) four-category model of attachment represent some of the more current attachment research exploring attachment with college students, relationships with peers and early family attachment history (Bartholomew & Horowitz) as well as romantic love (Hazan & Shaver, 1987) and love and work (1990) as attachment processes.

This paper draws on Bowlby (1969/1982, 1980) Ainsworth (1985) and Main and Solomon's (1990) valuable insights about the significance of early relationships in human development and the infant-caregiver tie as a secure base relationship. Attachment theory views the infant as one who is competent and motivated and who uses the primary caregiver as a secure base from which to explore and when necessary to use them as a haven of safety and a source of comfort. When the secure base is threatened, the infant's behaviors reflect a

problem with attachment, similar to problems found among homeless and runaway youth.

The aforementioned studies on homeless and runaway youth have provided valuable information on their characteristics and behaviors. This research is useful in understanding the patterns of homeless and runaway youth who have made the shelters or streets their home. While there has been an increasing amount of research on homeless and runaway youth, there has been a paucity of research focusing on a comprehension of the attachment bonds and close relationships that may describe the internal processes of these youth. Stefanidis et al.'s (1992) research on the effects of homeless and runaway youths' attachment history on their stabilization is important in reducing high risk behaviors which place homeless and runaway youth at risk for prostitution, substance abuse, HIV and AIDS infection (Rotherum-Borus et al., 1991) and the potential threat of suicide (Adam et al., 1996). The behavioral characteristics of the homeless and runaway adolescent are considered dysfunctional and self-destructive. These characteristics are indicative of what may be insecure attachment patterns to primary caregivers that may, in turn, reflect generational attachment patterns. The homeless and runaway youth may benefit from a service delivery model incorporating psychotherapy as an integral part of the treatment plan. The recent research on adolescents and attachment includes studies that are longitudinal (Allen et al., 1996; Rosenstein & Horowitz, 1996)

and have amplified the need for further research in the comprehension of attachment theory and its relationship to adolescent human development, psychological growth, and change.

The value of the Adult Attachment Interview (AAI) has already been established in empirical research with hospitalized adolescents and their mothers. Significant associations between the attachment classifications of post traumatic stress disorder; conduct disorder; and borderline, antisocial, and narcissistic personality disorders have been found in adolescent populations that have been hospitalized for psychiatric care. Further, hypothesized is the high correspondence between hospitalized adolescents attachment styles and maternal attachment (Rosenstein & Horowitz, 1996). More recent research has included paternal attachment as part of the Strange Situation laboratory research on attachment between fathers and their sons (Belsky, 1996).

Research in the area of attachment with homeless and runaway youth and their parents or caregivers may shed light on attachment with adolescents functioning at extremes. Secure attachment relationships remain crucial to human development and are related to psychological health and growth. Initiatives with homeless and runaway youth that are based on attachment theory and research may have implications for future research, long term interventions and treatment models for youth with severe adolescent psychopathology.

The numbers of homeless youth are increasing, with the numbers in California reaching up to 128,000 during the summer months. The majority are not considered poor, handicapped, or mentally ill, and they are from every race, religion and socioeconomic strata. They are in all likelihood running from severe family conflict, physical and sexual abuse, and economic hardships. Adolescence is a very small window of time in the process of human development. The homeless and runaway youth does not have much time that without secure base relationships, long term medical treatment, and mental health interventions that go beyond the crisis or short term, they will in all likelihood become the next generation of adult homeless.

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